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BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LORETA MINAS MONSALUD** **7777 South Jones Blvd., #1031** **Las Vegas, NV 89139** **Vocational Nurse License No. VN 201147** Respondent.	Case No. VN-2007-729 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians, Department of Consumer Affairs.

2. On or about September 23, 2002, the Board of Vocational Nursing and Psychiatric Technicians issued Vocational Nurse License Number VN 201147 to Loreta Minas Monsalud (Respondent). The Vocational Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2010, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118, subdivision (b), of the Code provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated

5. Section 2878 of the Code states:

> The Board may suspend or revoke a license issued under this chapter [the Vocational Nursing Practice Act (Bus. & Prof. Code, 2840, et seq.)] for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual nursing functions.
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> . . . .
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> (l) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Health Services developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, guidelines, and regulations pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300), Division 5, Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the California Medical Board, the Board of Podiatric Medicine, the Board of Dental Examiners, and the Board of Registered Nursing, to encourage appropriate consistency in the implementation of this subdivision.
> The board shall seek to ensure that licentiates and others regulated by the board are informed of the responsibility of licentiates and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of blood-borne infectious diseases.
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> . . . .

REGULATIONS

6. California Code of Regulations, Title 16, section 2518.6(a)(2) states:

> (a) A licensed vocational nurse shall safeguard patients'/clients' health and safety by actions that include but are not limited to the following:
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> . . .

(2) Documenting patient/client care in accordance with standards of the profession.

. . . .

7. California Code of Regulations, title 16, section 2519 defines gross negligence as:

As set forth in Section 2878 of the Code, gross negligence is deemed unprofessional conduct and is a ground for disciplinary action. As used in Section 2878 "gross negligence" means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed vocational nurse, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard of care.

8. California Code of Regulations, title 16, section 2520 defines incompetence as:

As set forth in Section 2878 of the Code, incompetence is deemed unprofessional conduct and is a ground for disciplinary action. As used in Section 2878 "incompetence" means the lack of possession of and the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by responsible licensed vocational nurses.

As set forth in Section 2878 of the Code, incompetence is deemed unprofessional conduct and is a ground for disciplinary action. As used in Section 2878 "incompetence" means the lack of possession of and the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by responsible licensed vocational nurses.

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

10. On or about March 22, 2005, an 82 year old female Patient, L.D., was admitted to Camarillo Convalescent Hospital (CCH) from St. John's Pleasant Valley Hospital with a diagnosis of right femur fracture, gait instability, decline in function, left lower extremity arthrodesis[1] and

[1] Arthrodesis is a surgical procedure, also known as joint fusion. The goal of arthrodesis is to provide pain relief, restore skeletal stability, and improve alignment sometimes performed for people with advanced arthritis.

anxiety. The admission history stated she had the capacity to understand and make decisions and had fair to good rehabilitation potential. The admission orders included placement of a Foley catheter #16 and to monitor the catheter, change the catheter or bag when needed, and monitor the urine for sediment, cloudiness, odor or blood and report any such findings to the physician.

11. CCH protocols for Daily Urinary Catheter care required staff to check the urine for unusual appearance in color, odor and sediment and to accurately document the findings.

12. On or about April 17, 2005, patient L.D. was told by a physical therapist that her urine was green in color.

13. On April 18, 2005, the patient's daughter observed a greenish tinge to her mother's catheter tube and a dark brown area in the tube just above the catheter bag.

14. On April 18, 19 and 30, 2005, respondent was assigned to care for patient L.D. Her nursing notes on each of these days failed to document the color or condition of the patient's urine as required by the patient's individual care plan.

15. On April 19, 2005, the nursing notes state that the urinary catheter was changed on April 19, 2005, but gave no reason for the change and failed to document the urine color at the time the new catheter was inserted

16. On April 20, 2005, patient L.D. was observed to be cold and clammy, with a blood pressure of 70/40, heart rate of 80 and respiratory rate of 30 with an O2 saturation of 86%. She was transferred to the St. John's Pleasant Valley Emergency Department where she was diagnosed with a urinary tract infection and urosepsis,[2] E-Coli (type of bacteria) infection, hyperkalemia (high potassium level) and volume depletion. L.D. was weak, sweaty, and nauseated and was admitted to the hospital.

17. On or about April 23, 2005, patient L.D. was transferred back to CCH, in stable condition. Her admission records from CCH contained doctor's orders for catheter care and

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[2] Urosepsis is the acute condition of a systemic infection in the blood that develops secondary to a urinary tract infection (UTI), and then circulates throughout the entire body. A lay term for this critical condition is blood poisoning because an infection is in the bloodstream. Sepsis, if not treated properly, may result in major organ damage, septic shock or death.

antibiotics. Between April 23 and April 25, 2005, her urine was documented as ranging in color from yellow to amber and the patient was alert, verbally responsive with stable vital signs.

18. On April 30, 2005, Respondent provided the nursing care to patient L.D. On this date, the patient reported feeling dizzy and her blood pressure was 70/40, but no pulse or respiratory rates were recorded. The patient was noted to be diaphoretic and she was returned to bed. She was placed on oxygen with an oxygen saturation of 90%. There is no documentation that the physician was notified of the hypotensive episode. At 3:00 p.m. L.D. was noted to be cold and clammy with a complaint of back pain, her oxygen saturation was at 93%, her blood sugar level was at 250 and her blood pressure was 90/58, with no documentation of pulse or respiration rate. There is no evidence that the patient's doctor was notified of the patient's condition or continued low blood pressure. At 4:30 p.m. the patient received insulin for her elevated blood sugar. At 10:30 p.m. the nursing documentation states that the patient refused dinner and only had a piece of cake and milk.

19. On May 1, 2005, patient L.D.'s blood pressure was 84/48. She complained of back pain, and stated "I can't breathe." The nursing staff could not obtain a blood pressure reading and her pulse was 38. A physician was notified and 911 called. When the paramedics arrived the patient was awake, alert, oriented to person, place time and purpose, skin was moist and cool and she was pale. They could not get a blood pressure reading, her pulse was 58 and they could not get an IV started. She was admitted to St. John's Pleasant Valley Hospital where her O2 saturation level could not be obtained. She was admitted to the intensive care unit and passed away shortly after midnight on May 2, 2005. The cause of death was stated as "septic shock, urinary tract infection" with Diabetes type 2, hypertension and chronic back pain.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent is subject to disciplinary action under section 2878(a)(1) in that she committed gross negligence in her care and treatment of patient L.D. by :

a. Failing to follow the care plan for patient L.D. which required daily observation and documentation of patient L.D.'s urine output, including the color, odor, and/or presence of

blood or sediment, cloudy urine, scant urine, discolored urine and whether the patient had a fever; and

b. Failed to notify the physician of the hypotensive episode and the patient's continued low blood pressure.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

21. Respondent is subject to disciplinary action under section 2878(a)(1) in that she displayed incompetence in her care and treatment of patient L.D. by failing to follow established policy and the care plan for patient L.D., which required daily observation and documentation of patient L.D.'s urine output, including the color, odor, and/or presence of blood or sediment, cloudy urine, scant urine, discolored urine and whether the patient had a fever. She also failed to notify the patient's physician on April 30, 2005, of the hypotensive episode as set forth above in paragraphs 8 through 17.

THIRD CAUSE FOR DISCIPLINE

(Knowing Failure to Follow Infection Control Guidelines)

22. Respondent is subject to disciplinary action under section 2578(l) in that she failed to follow infection control guidelines in her care and treatment of patient L.D. by failing to follow established policy and the care plan for patient L.D. which required daily observation and documentation of patient L.D.'s urine output, including the color, odor, and/or presence of blood or sediment, cloudy urine, scant urine, discolored urine and whether the patient had a fever as set forth above in paragraphs 8 through 17.

FOURTH CAUSE FOR DISCIPLINE

(Failing to Document Patient Care in Accordance With Standards of the Profession)

23. Respondent is subject to disciplinary action under California Code of Regulations, Title 16, section 2518.6(a)(2) in that she failed to document patient L.D.'s urine output, including the color, order, and/or presence of blood or sediment, cloudy urine, scant urine, discolored urine and whether the patient had a fever as set forth above in paragraphs 8 through 17.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians issue a decision:

1. Revoking or suspending Vocational Nurse License Number VN 201147, issued to Loreta Minas Monsalud;

2. Ordering Loreta Minas Monsalud to pay the Board of Vocational Nursing and Psychiatric Technicians the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: November 5, 2010.

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
Department of Consumer Affairs
State of California
Complainant

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